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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **GARY ANTHONY THOMPSON** **673 Candlestick Court** **Turlock, CA 95382** **Registered Nurse License No. 628864** Respondent.	Case No. 2012-1 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about November 5, 2003, the Board issued Registered Nurse License Number 628864 to Gary Anthony Thompson ("Respondent"). Respondent's registered nurse license expired on October 31, 2009.

STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct . . .

6. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law . . . any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
>
> . . . .
>
> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

7. Health and Safety Code section 11173, subdivision (a), states, in pertinent part, that "[n]o person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge . . ."

COST RECOVERY

8. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES

9. "Dilaudid" , a brand of hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(K).

10. "Lorazepam" is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(16).

11. "Morphine" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M).

FIRST CAUSE FOR DISCIPLINE

(Diversion of Controlled Substances)

12. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (a), in that while on duty as a registered nurse in the Emergency Department at Emanuel Medical Center located in Turlock, California, Respondent obtained the controlled substances Dilaudid, lorazepam, and morphine by fraud, deceit, misrepresentation, or subterfuge, in violation of Health and Safety Code section 11173, subdivision (a), as follows: In or about February 2009 and March 2009, Respondent removed various quantities of Dilaudid, lorazepam, and morphine from the medical center's Omnicell (an automated medication dispensing machine requiring password sign-on for access), for certain patients when there were no physicians' orders authorizing the medications for the patients. Further, Respondent failed to chart the administration of the controlled substances on the patients' Medication Administration Records ("MAR"), failed to document the wastage of the controlled substances in the Omnicell, and/or falsified or made grossly incorrect, grossly inconsistent, or unintelligible entries in the patients' emergency records to conceal his diversion of the controlled substances, as set forth in paragraph 13 below.

SECOND CAUSE FOR DISCIPLINE

(False Entries in Hospital/Patient Records)

13. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (e), in that while on duty as a registered nurse in the Emergency Department ("ED") at Emanuel Medical Center located in Turlock, California, Respondent falsified, or made grossly

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incorrect, grossly inconsistent, or unintelligible entries in hospital, patient, or other records pertaining to the controlled substances Dilaudid, lorazepam, and morphine, as follows:

Patient A

a. On March 5, 2009, Respondent wrote on the ED Physician Record an order for Dilaudid 2 mg for the patient when, in fact, the order was not authorized in that the ED prohibited the acceptance of verbal orders from physicians. Further, at 6:04 a.m. that same day, Respondent removed Dilaudid 2 mg from the Omnicell for the patient, charted on the patient's MAR that he administered 1 mg Dilaudid to the patient at 5:45 a.m., but documented in the Omnicell that he wasted *1.5* mg Dilaudid at 6:18 a.m. as witnessed by nurse W. K.

b. On March 5, 2009, Respondent wrote on the ED Physician Record an order for lorazepam 2 mg for the patient when, in fact, the order was not authorized in that the ED prohibited the acceptance of verbal orders from physicians. Further, at 6:35 a.m. that same day, Respondent removed lorazepam 2 mg from the Omnicell for the patient, charted on the patient's MAR that he administered 1 mg lorazepam to the patient at 6:30 a.m., but failed to document the wastage of the remaining 1 mg lorazepam in the Omnicell or otherwise account for the disposition of the lorazepam 1 mg.

Patient B:

c. On February 18, 2009, Respondent wrote on the ED Physician Record an order for Dilaudid 0.5 mg for the patient when, in fact, order was not authorized in that the ED prohibited the acceptance of verbal orders from physicians. Further, at 10:46 a.m. that same day, Respondent removed Dilaudid 2 mg from the Omnicell for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Omnicell, and otherwise account for the disposition of the Dilaudid 2 mg.

d. On February 18, 2009, at 11:03 a.m., Respondent removed morphine 4 mg from the Omnicell for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the morphine on the patient's MAR, document the wastage of the morphine in the Omnicell, and otherwise account for the disposition of the morphine 4 mg.

Patient D

e. On February 17, 2009, at 5:09 p.m., Respondent removed Dilaudid 2 mg from the Omnicell for the patient when, in fact, there was no physician's order authorizing the medication for the patient at that time. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Omnicell, and otherwise account for the disposition of the Dilaudid 2 mg.

Patient G

f. On February 16, 2009, at 3:38 p.m., Respondent removed morphine 4 mg from the Omnicell for the patient and charted on the patient's MAR that he administered Morphine 4 mg to the patient at 3:30 p.m., when, in fact, there was no physician's order authorizing the medication for the patient at that time.

Patient J

g. On February 3, 2009, at 12:08 p.m., Respondent removed Dilaudid 2 mg from the Omnicell for the patient when, in fact, there was no physician's order authorizing the medication for the patient at that time. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Omnicell, and otherwise failed to account for the disposition of the Dilaudid 2 mg.

Patient L

h. On February 2, 2009, at 11:30 a.m., Respondent wrote on the ED Physician Record an order for Dilaudid .5 mg for the patient when, in fact, the order was not authorized in that the ED prohibited the acceptance of verbal orders from physicians. Further, at 12:08 p.m. that same day, Respondent removed Dilaudid 2 mg from the Omnicell for the patient, but failed to chart the administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Omnicell, and otherwise account for the disposition of the Dilaudid 2 mg.

Patient M

i. On February 2, 2009, between 7:25 a.m. and 9:08 a.m., Respondent removed a total of 6 mg of Dilaudid from the Omnicell for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the

administration of the Dilaudid on the patient's MAR, document the wastage of the Dilaudid in the Omnicell, and otherwise account for the disposition of the Dilaudid 6 mg.

Patient P

j. On February 17, 2009, at 3:11 p.m., Respondent removed Dilaudid 2 mg from the Omnicell for the patient and charted on the patient's MAR that he administered Dilaudid 2 mg to the patient at 3:15 p.m., when, in fact, there was no physician's order authorizing the medication for the patient at that time.

Patient DD:

k. On February 4, 2009, at 8:07 a.m., Respondent removed Dilaudid 2 mg from the Omnicell for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent charted on the patient's MAR that he administered Dilaudid 1 mg to the patient at 7:30 a.m., but documented in the Omnicell that he wasted the entire 2 mg of Dilaudid at 9:40 a.m. as witnessed by nurse G. M.

l. On February 4, 2009, at 8:07 a.m., Respondent removed lorazepam 2 mg from the Omnicell for the patient when, in fact, there was no physician's order authorizing the medication for the patient at that time. Further, Respondent charted on the patient's MAR that he administered lorazepam 1 mg to the patient at 8:00 a.m., but failed to document the wastage of the remaining 1 mg lorazepam in the Omnicell or otherwise account for the disposition of the lorazepam 1 mg.

Patient FF

m. On February 8, 2009, at 1:03 p.m., Respondent removed Dilaudid 2 mg from the Omnicell for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent documented in the Omnicell at 1:08 p.m. that he wasted Dilaudid 1.5 mg as witnessed by nurse A. T., but failed to chart the administration of any portion of the Dilaudid on the patient's MAR or otherwise account for the disposition of the remaining Dilaudid .5 mg.

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Patient HH

n. On February 2, 2009, at 5:37 p.m., Respondent removed Dilaudid 2 mg from the Omnicell for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent documented in the Omnicell at 6:14 p.m. that he wasted Dilaudid 1 mg as witnessed by nurse A. O., but failed to chart the administration of any portion of the Dilaudid on the patient's MAR or otherwise account for the disposition of the remaining Dilaudid 1 mg.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 628864, issued to Gary Anthony Thompson;

2. Ordering Gary Anthony Thompson to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: July 7, 2011

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SA2011100207